The Health of New Hampshire's Community Hospital System

A Financial Analysis

Frisbie Memorial Hospital




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An Important Message to Readers of the Hospital Financial Analysis from the New Hampshire Department of Health and Human Services

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Introduction

The following Hospital Financial Analysis is a byproduct of the December 13 report, *The Health of New Hampshire's Community Hospital System*, issued by the New Hampshire Department of Health and Human Services. The individual financial narratives are part of a series of analyses addressing the financial condition of the state's health care system.

In the following report, you will find an analysis of the hospital's financial well being from 1993-1998, and **then an additional analysis** that covers the most recent period for which information is currently available, 1999. As audited financial statements for 2000 become available from the hospitals, this information will be updated.

Each hospital financial analysis is broken into five sections. These include:

- Background information on the hospital size, location, payor mix and affiliates;
- A Summary of the Financial Analysis;
- A Cash Flow Analysis;
- An Analysis of Profitability, Liquidity and Capital; and
- An Estimation of Charity Care and Community Benefits

Financial Benchmarks

Financial benchmarks include traditional measures of profitability, liquidity, solvency, and cash flow. Each of these areas of analysis is defined below. Additional information about the ratios or the nature of financial analysis can be obtained by consulting health care financial texts (Gibson 1992; Cleverley 1992).

Profitability:	Purpose	Calculation
Total Margin	Measures the organization's ability to cover expenses with revenues from all sources	Ratio of (Operating Income and Nonoperating Revenues)/Total Revenues
Operating Margin	Measures the organization's ability to cover operating expenses with operating revenues	Ratio of Operating Income/Total Operating Revenue
PPS Payment/Cost	Measures the relationship between Medicare PPS payments and Medicare PPS costs; numbers above 1 indicate that payments exceed costs	Ratio of Medicare Prospective Payment System (PPS) Payments /PPS Costs, derived from Medicare Cost Reports
Non-PPS Payment/Cost	Measures the relationship between payment and costs of all payment sources other than Medicare PPS[1]	Ratio of (Total Operating Revenue minus PPS Payments) / (Total Operating Cost minus PPS Costs)
Markup Ratio	Measures the relationship between hospital-set charges and hospital operating costs; generally only self-pay and indemnity payers pay hospital charges	Ratio of (Gross Patient Service Charges Plus Other Operating Revenue) / Total Operating Expense
Deductible Ratio	Measures the relationship between hospital's contractual discounts negotiated with (private payers) or taken by payers (Medicare and Medicaid) and hospital charges	Ratio of Contractual Adjustments/Gross Patient Service Revenue
Nonoperating Revenue Contribution	Measures the contribution of nonoperating revenues (activities that are peripheral to a hospital's central mission) to total surplus or deficit	Ratio of Nonoperating Revenues (includes unrestricted donations, investment income, realized gains (losses) on investments and peripheral activities)/Excess Revenue over Expense
Realized Gains to Net Income	Measures the contribution of realized gains (a subset of nonoperating revenues) to total surplus or deficit	Ratio of realized gains (losses)/Excess Revenue over Expense

[1] Medicare's Prospective Payment System includes only inpatient-related operating and capital costs and excludes Medicare payments for outpatient costs, which have not been part of PPS through 1998

Liquidity:		
Current Ratio	Measures the extent to which current assets are available to meet current liabilities	Current Assets/Current Liabilities
Days in Accounts Receivables	Measures how quickly revenues are collected from patients/payers	Patient Accounts Receivable/(Net Patient Service Revenue / 365)
Average Pay Period	Measures how quickly employees and outside vendors are paid by the hospital	(Accounts Payable and Accrued Expenses)/ (Average Daily Cash Operating Expenses)[2]
Days Cash on Hand	Measures how many days the hospital could continue to operate if no additional cash were collected	(Cash plus short-term investments plus noncurrent investments classified as Board Designated)/(Average Daily Cash Operating Expenses)
Solvency:		
Equity Financing Ratio	Measures the percentage of the hospital's capital structure that is equity (as opposed to debt, which must be repaid)	Unrestricted Net Assets/Total Assets
Cash Flow to Total Debt	Measures the ability of the hospital to pay off all debt with cash generated by operating and nonoperating activities	(Total Surplus (Deficit) plus Depreciation and Amortization Expense)/Total Liabilities
Average Age of Plant	Measures the relative age of fixed assets	Accumulated Depreciation/ Depreciation Expense

Hospitals As Integrated Systems of Care

Many of New Hampshire's hospitals have developed into systems of care with complex corporate organizational structures. Hospitals may be owned by a holding company or may themselves own other subsidiaries. (The hospital corporate organization charts will be made available with these financial narratives at a future date.) These individual analyses that follow attempt to isolate the hospital entity to the extent possible as the basis of analysis. This distinction is important because subsidiaries that operate within a larger hospital system may operate at higher or lower levels of financial performance than the hospital. For example, a home health agency impacted by Medicare reimbursement changes that result in an operating deficit might be directly supported by the hospital. On the other hand, an ambulatory surgical unit (or another entity within the holding company of which the hospital is a part of) with a healthy financial performance could have a positive impact on the hospital with an operating deficit.

[2] (Operating Expenses Less Depreciation Expense Less Bad Debt Expense)/365

Charity Care and Community Benefits

Each hospital financial analysis includes a section on Charity Care and Community Benefits. This section of the hospital financial narrative is more exploratory than are the other standardized financial benchmarks. For further background information or for specific information on how these measures were calculated, please see the *Analysis of Health Care Charitable Trusts in the State of New Hampshire.*

In 1999, the legislature passed the New Hampshire Community Benefits law (SB 69), which requires that all non-profit hospitals and other health care charitable trusts with $100,000 or more in their total fund balance complete a needs assessment of the communities that they serve. The legislation also calls for the hospitals and others to consult with members of the public within their communities to discuss what the provider has done in the past to meet community needs, what it plans to do in the future, and then submit the plan to the Attorney General's office.

New Hampshire's law is a reporting statute. It does not contain a dollar value or minimum threshold the non-profit trusts must meet. With this new statute, the hospitals and others are working to improve the measurement of charity care (free care) and other community benefits they provide in return for exemption from local, state and federal taxes. Since this law is relatively new, the audited financial statements used for the purpose of this community benefit analysis may not yet fully reflect the dollar value of community benefits beyond charges foregone for charity care or necessary but unprofitable services. New Hampshire's definition of community benefits is very broad; it includes free care but does not include bad debt or shortfalls in reimbursement from the Medicare and Medicaid programs.

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For More Information

Questions or comment concerning this report may be directed to the Office of Planning and Research at 603-271-5254.

MOODY'S BOND RATING: BAA 1

FRISBIE MEMORIAL HOSPITAL
ROCHESTER, NEW HAMPSHIRE
1993 – 1999 FINANCIAL ANALYSIS

Frisbie Memorial Hospital is an 88 bed, acute-care facility primarily serving residents of Strafford County[3]. As of 1997, private insurers and Medicare represented the largest percentage of payers for inpatient discharges (39 and 38%, respectively)[4].

Financial statements include data for the hospital and its wholly-owned subsidiaries: Frisbie Health Services, Inc., a not-for-profit (NP) corporation consisting of physician practices in Farmington and Rochester; Frisbie Foundation, Inc., a NP company that holds various investments and properties; and Seacoast Business and Health Clinic, a for-profit corporation providing outpatient health services. These are collectively referred to as the "System." Frisbie Memorial Hospital has half ownership of Strafford Health Alliance, a NP provider of mammography screening (Women's Life Screening) and other healthcare related services (Marshall Rehab), and Health Circle, Inc. (both co-owned with Wentworth-Douglass Hospital). A land investment called the Meadows at Madbury, which was the planned site for a future nursing home facility was sold in 1998. These investments are accounted for by the equity method.

Supplemental information was provided that allowed us to evaluate separately financial data for the hospital only from 1994 to 1998. Gross patient service revenue data was not reported in the footnotes to the audited financial statements. We, therefore, used Medicare Cost Report data available from 1994 to 1997 to calculate markup and deductible ratios and to benchmark charity care as a percentage of gross patient service revenues.

Summary of Financial Analysis 1993-98

The hospital is the strongest entity financially in the Frisbie Hospital System. Forty-six percent of the System's cash over the period was generated by income. Profit margins were high and driven mainly by strong and increasing operating margins; and the sale of an affiliate in 1995 further boosted the bottom line. The system used 48% of its cash on property, plant and equipment (PP&E), thereby lowering its average age of plant over the period to a relatively young 6.9 years. The rest of cash generated was used to increase cash and marketable securities balances. As a result, the System is highly liquid. Solvency steadily improved over the period, resulting in the System's relatively debt-free capital structure by 1998. Overall, improving profitability, liquidity and solvency measures indicate that the System is financially strong and sustainable.

Cash Flow Analysis 1993-98

The System generated $46M of its total cash over the six-year period from net income, as reflected in high profit margins. With Frisbie Foundation's sale of its investment in PathLab, the System generated an additional 20% of its total cash sources and was, therefore, able to rely mostly on equity rather than debt sources of capital to cover investing activities.

The System spent close to half its cash ($24M) on investments in property, plant and equipment (PP&E). This amount was 85% greater than depreciation expense for the period ($13M). As a

[3] 1998 American Hospital Association Guide.

[4] 1997 data from the State of New Hampshire Department of Health and Human Services.

result, the average age of plant declined to reach a low 6.9 years in 1998. Most of the remaining cash was used to increase cash reserves (36%) and invested in marketable securities (13%).

The System increased long-term borrowing in 1993 to turn over outstanding debt. The amount issued exceeded the amount repaid over the period, providing the hospital with some extra cash to use for investing or other purposes.

Since financial statements were consolidated, inter-party transactions between the hospital and subsidiaries were not captured in the cash flow analysis. Supplemental information to the financial statements indicated that the hospital transferred approximately $1.1M to Frisbie Health Services between 1997 and 1998, in addition to a loan of approximately $1.1M. The hospital also transferred $1.2M to Frisbie Foundation in 1998.

Ratio Analysis 1993-98[5]

Profitability

The System's strong profit margins were driven by operating profits. The operating margin increased over the period, from break even to 10%, following an increased markup of charges over costs that offset growth in deductions to revenues from payer discounts and contractuals.

The hospital alone produced stronger operating margins than the System, at 13% in both 1997 and 1998. The operating losses of Frisbie Health Services (physician practices) lowered the margins for the System to 9 – 10%. The hospital's total margins were also higher than the System's (ranging from 11 to 16% versus 5 to 14%, respectively).

The contribution of nonoperating revenues to the System's total income decreased as operating margins improved. After 1995, nonoperating revenues consistently contributed approximately one-third of the System's bottom line. It appears that dividend and interest income comprised most of the nonoperating contribution. Since the hospital's operating margins were stronger than the System's, the contribution of nonoperating revenues to the total margin was less for the hospital than for the System as a whole.

Though the System and hospital's continued strong profitability performance appears sustainable since it relies mostly on operating income, this will depend on the continued ability to collect the relatively high (180% as of 1997) markup from third party payers.

Liquidity

The System's liquidity is strong, again driven by the strong liquidity position of the hospital alone. The current ratio steadily improved and showed that the System was easily able to meet current liabilities with its short-term assets.

While plant has been well maintained, the System's cash position is also very strong. The System's days cash on hand for short term and all sources reached 235 and 400 days, respectively, by 1998. The hospital alone has 147 and 336 days cash on hand with short-term and total sources. (Note: the increase in this measure between 1996 and 1997 may be partly due to an accounting principal change requiring certain investments to be recorded at market value rather than historical cost).

[5] NH state medians from The 1998-99 Almanac of Hospital Financial & Operating Indicators.

Working capital was managed well, with overall improvements in days in accounts receivable, indicating improved collections, and in the average pay period, indicating improvements in payments to vendors. As a result, net working capital was a source of cash for the System.

Capital Structure

The capital structure of the System mainly represents the long-term borrowing of the hospital. As illustrated by the equity financing ratio, the System was fairly leveraged at the beginning of the period due to low profitability and the issuance of new debt in 1993. This ratio steadily improved as high profit margins caused growth in net assets (equity), reducing the System's overall financial risk. (Note: the growth in net assets and subsequent improvement in capital structure between 1996 and 1997 may be partly due to the accounting principal change discussed above.) The long-term debt to equity ratio follows a similar trend, decreasing (improving) steadily and significantly over the period.

High profitability bolstered the System's ability to cover debt. Debt service coverage ratios steadily improved and show that both the System as a whole and the hospital alone produce enough cash flow from yearly income to cover debt principal and interest payments easily. Even cash flow from operating income alone covers the debt service many times over.

By 1998, the System's cash flow from operating income is strong enough to cover one-third of the total amount of outstanding long-term debt. The hospital alone produced enough cash from operating income in 1997 to cover one-third of its total debt, which is the median for other New Hampshire hospitals when all income sources are considered.

Charity Care and Community Benefits

We were only able to evaluate the provision of charity care from 1994 to 1997 due to missing gross patient service revenue data as stated above. Charity care reported as charges forgone generally represented less than 3% of gross patient service revenues and declined with increasing profitability, reaching 1.6% in 1997. Free care with 100% bad debt met the estimated value of the hospital's tax exemption. Charity care did not meet the value of the hospital's tax exemption in the other years.

The hospital did not report additional charity care/community benefits in the footnotes to its financial statements.

In addition to charity care, the hospital offers HIV/AIDS services, which may be considered an additional charitable benefit to the community[1].

Cash Flow Analysis 1993 - 1999

Frisbie Memorial Hospital and Subsidiaries (the "system") generated 50% of its total cash over the seven-year period from net income. This is reflected in the System's profit margins.

The System spent close to half its cash—$30 million—on investments in property, plant, and equipment (PP&E). The average age of the plant declined to reach a low 6.9 years in 1998 and 7.5 years in 1999. Most of the remaining cash was used to increase cash (34%), and marketable securities (11%) in 1999.

Since financial statements were consolidated, inter-party transactions between the hospital and subsidiaries were not captured in the cash flow analysis. Supplemental information to the financial statements indicated that the hospital transferred approximately $0.6 million in 1999 to Frisbie Health Services. The hospital also transferred $1.4 million to The Frisbie Foundation in 1999.

1999 Ratio Analysis

Profitability

The total margin and operating margin were 12% and 8% respectively in 1999. The hospital alone produced operating margins of 9.5%. The operating losses of Frisbie Health Service, a physician practice, lowered the margin for the System to 8%. The total margin for the hospital in 1999 was 13.3%.

The non-operating revenue gains contributed 41% of the system's bottom line in 1999.

The System and hospital profitability performance appears sustainable since it relies mostly on operating income. This profitability will continuously depend on the ability of the hospital and System to collect from third party payors and maintain the current payor mix of 41% Medicare, 51% commercial and self pay, and 8% Medicaid.

Liquidity

The system's liquidity continues to be strong in 1999. The current ratio steadily improved and showed that the System was easily able to meet current liabilities with its short-term assets.

While the plant has been well maintained, the System's cash position is also very strong. The System's days cash on hand for short-term and all sources was 231 and 427 days, respectively. This is well above both national and regional averages in 1997, being 118.8 days and 110.2 days respectively. The cash position of the system is also well above New Hampshire - in the 75th percentile in 1999 at 348.14 days.

$374,000 of cash was used for working capital.

Capital Structure

Equity financing was a relatively debt-free 75%. The long-term debt to equity ratio was 24%. This was due to the hospital's profitability. The debt service coverage ratio was 5.58. This also demonstrates a strong financial position. Debt service coverage using operating income rather than total income is a healthy 4.2.

Charity Care and Community Benefits
Charges forgone were $1.5 million in 1999. This represented 2% of gross patient service revenue.

There were no additional charity care/community benefits disclosed in the footnotes to the hospital's financial statements.

Summary
The system has a strong financial position. The System's operating margin is above both 1997 regional and national averages. The strong liquidity and low debt have also demonstrated the strong financial position of the hospital.

Source: Audited Financial Statements. Prepared by Nancy M. Kane, D.B.A. Harvard School of Public Health